The Seventh Circuit Court of Appeals properly applied Illinois law. Petitioner's Petition presents no reason, let alone a compelling reason, to warrant granting a writ of certiorari.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari must be denied.

Respectfully submitted,

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No. 05-946

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In The

Supreme Court of the United States

IRENE M. GESCHKE, INDIVIDUALLY AND AS EXECUTOR OF THE ESTATE OF CLARENCE O. GESCHKE,

Petitioner,

v.

AIR FORCE ASSOCIATION AND MONUMENTAL LIFE INSURANCE COMPANY,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

REPLY TO BRIEF IN OPPOSITION

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TABLE OF CONTENTS

Page

Table of Contents i

Table of Authorities ii

Respondents' Objection Misapprehends the Question Petitioner Presents for Review and Addresses in the Petition for Certiorari 1

Respondents' Restrictive View of Rule 10 is Wrong and Disregards the Court's Discretion with Regard to Petitions for Certiorari 1

Reply to Points Raised in Brief in Opposition 2

Respondents' Points Concerning Blood and Plasma Benefit Rider Treat the CancerCare Plan Contract as a Collection of Separate, Isolated Documents, Not a Single Unified Whole 2

Respondents' Point That CancerCare Plan Does Not Cover All Cancer Treatment is Moot, and Does Not Address Seventh Circuit's Erroneous Holding That CancerCare Does Not Cover Any Cancer Treatment 5

Respondents' Points Concerning Omission in the "Blood And Plasma Benefit Rider" of the Word "Treatment" and Any Reference to Blood Processing and Transfusion Costs are Overruled by the Circumstances Surrounding the CancerCare Plan 8

Conclusion 10

TABLE OF AUTHORITIES

Page

CASES

Allstate Insurance Co. v. Smiley, 276 Ill.App.3d 971, 659 N.E.2d 1345, 213 Ill.Dec. 698 (2 Dist. 1995) 8

American States Insurance Co. v. Koloms, 177 Ill.2d 473, 687 N.E.2d 72, 227 Ill.Dec. 149 (Ill. 1997) 4

Bourke v. Dun & Bradstreet Corp., 159 F.3d 1032 (C.A.7 1998) 1, 3, 4, 7

Commonwealth Insurance Co. v. Stone Container Corp., 351 F.3d 774, rehearing denied (C.A.7 [Ill.] 2003) 9

Employers Insurance of Wausau v. Ehlco Liquidating Trust, 186 Ill.2d 127, 708 N.E.2d 1122, 237 Ill.Dec. 82, rehearing denied, on remand, 309 Ill.App.3d 730, 723 N.E.2d 687, 243 Ill.Dec. 384, appeal denied, 188 Ill.2d 563, 729 N.E.2d 495, 246 Ill.Dec. 122 (Ill. 1995) 9

Flora Bank & Trust v. Czyzewski, 222 Ill.App.3d 382, 164 Ill.Dec. 804, 583 N.E.2d 720 (1991) 4

Indiana Insurance Co. v. Pana Community Unit School District No. 8, 314 F.2d 895 (C.A.7 [Ill.] 2002) 7

O'Rourke v. Access Health, Inc., 282 Ill.App.3d 394, 218 Ill.Dec. 51, 668 N.E.2d 214 (1996) 3

United States Fire Insurance Co. v. Schnackenberg, 88 Ill.2d 1, 429 N.E.2d 1203, 57 Ill.Dec. 840 (Ill. 1983) 3

TABLE OF AUTHORITIES – Continued

Page

ARTICLES

Stephen M. Shapiro "Certiorari Practice: The Supreme Court's Shrinking Docket" Mayer, Brown, Rowe & Maw Appellate.Net Supreme Court and Appellate Practice Group, www.appellate.net, pg. 6 2

___, "Granting Certiorari: How does the Supreme Court decide which cases to decide?", search.yahoo.com (referencing Perry, H.W., *Deciding to Decide, Agenda Setting in the United States Supreme Court*, Cambridge, Mass.: Harvard University Press, 1991) 2

RULES

United States Supreme Court Rule 10 2

RESPONDENTS' OBJECTION MISAPPREHENDS THE QUESTION PETITIONER PRESENTS FOR REVIEW AND ADDRESSES IN THE PETITION FOR CERTIORARI

The United States Court of Appeals for the Seventh Circuit in its *de novo* review of the summary judgment entered in this case ignored Illinois law governing contract interpretation, and disregarded or misstated pertinent evidence in the record as to the meaning of the contract language in dispute. "Contract interpretation, including the question of whether a contract is ambiguous, involves conclusions of law." *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d 1032, 1036 (C.A.7 1998). The Circuit's error in how it determined a matter of law is the subject of the petition for writ of certiorari, and is an issue within the question presented for review. And of course the question raised is not, contrary to Respondents (Brief in Opposition [hereinafter, "Brief"] pp. 1, 2, 6, 8) merely whether the Circuit's interpretation of the contract language was correct (although it obviously was not).

Respondents' Brief does nothing to demonstrate that in interpreting that language the Seventh Circuit followed controlling state law, and that the Circuit's affirmation of the summary judgment was in any way a defensible ruling.

RESPONDENTS' RESTRICTIVE VIEW OF RULE 10 IS WRONG AND DISREGARDS THE COURT'S DISCRETION WITH REGARD TO PETITIONS FOR CERTIORARI

Contrary to the Respondents (Brief pp. 1, 2, 6), the Supreme Court emphasizes in Rule 10 that the possible reasons stated therein for granting a petition for writ of certiorari neither control nor fully measure the Court's judicial discretion. In this case, Petitioner believes that the question presented for review and the argument

(citing pertinent evidence) support granting the petition pursuant to the third reason described in Rule 10(a).

The Court is aware that in exercising its judicial discretion it has granted certiorari in cases of "egregious error" involving "extraordinarily harsh and unreasonable results on the record." Stephen M. Shapiro "Certiorari Practice: The Supreme Court's Shrinking Docket" Mayer, Brown, Rowe & Maw Appellate.Net Supreme Court and Appellate Practice Group, www.appellate.net, pg. 6; ___, "Granting Certiorari: How does the Supreme Court decide which cases to decide?", search.yahoo.com (referencing Perry, H.W., *Deciding to Decide, Agenda Setting in the United States Supreme Court*, Cambridge, Mass.: Harvard University Press, 1991). In this case, the Seventh Circuit's affirmation of a summary judgment, based on its erroneous approach to construing contract language, creates a "compelling reason" for granting the petition.

REPLY TO POINTS RAISED IN BRIEF IN OPPOSITION

Respondents' Points Concerning Blood and Plasma Benefit Rider Treat the CancerCare Plan Contract as a Collection of Separate, Isolated Documents, Not a Single Unified Whole

According to the Seventh Circuit: (1) The CancerCare Plan was articulated in a policy and a number of separate and isolated riders; (2) Only one rider actually provided any coverage for cancer treatment; (3) The balance of the CancerCare Plan had nothing to do with providing "cancer treatment or any treatment at all."; (4) Consequently, the "Blood and Plasma Benefit Rider" language – "expenses for the cost of blood and blood plasma" – whose meaning the parties dispute is to be understood as covering only the cost of the physical substance, not typing it and administering it to the cancer patient. (Petition for Certiorari [hereinafter "Pet."] Appendix [hereinafter "App."] 10-11)

Respondents argue certain points concerning the "Blood and Plasma Benefit Rider" that are grounded on the Seventh Circuit's view of the CancerCare Plan as consisting of separate, isolated documents – the policy, the riders, the amendments – rather than together, as one single contract. (Brief pg. 8) But the opening sentence in every one of the seven riders states, "This Rider is a part of the Policy to which it is attached." And each of the five amendments contains language relating it back to the policy. (The riders and amendments are in Exhibit D to the petitioner's opening brief to the Seventh Circuit.)

"Illinois law requires that we do not look at the contested language in isolation. We 'examine [the contract] as a whole, giving effect, to the extent possible, to all contractual provisions.' *O'Rourke v. Access Health, Inc.*, 282 Ill.App.3d 394, 218 Ill.Dec. 51, 57, 668 N.E.2d 214, 220 (1996) (internal citations omitted)." *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d at 1038. "All the provisions of an insurance contract, rather than an isolated part, should be read together to interpret it and to determine whether an ambiguity exists." *United States Fire Insurance Co. v. Schnackenberg*, 88 Ill.2d 1, 5, 429 N.E.2d 1203, 1205, 57 Ill.Dec. 840 (Ill. 1983). (App. 8-9) This law simply was not followed by the Seventh Circuit.

In the Seventh Circuit's Opinion in this case, in the key passage therein where the Circuit actually interprets the language in question, the Circuit asserts that only one rider, the "Extended Hospital Expenses Benefit Rider," did "under limited circumstances, provide coverage for cancer treatment." According to the Circuit, that made it a "special rider" providing a cancer treatment benefit "distinct from all the other defined benefits included in the plan and the other riders." (App. 10-11) But contrary to the Circuit, the insurer (Monumental Life Insurance Company) who drafted the "Extended Hospital Expenses Benefit Rider" did not designate it as "special" or distinguish it from the policy's other amendments and its riders. There is absolutely no language in the rider (and the

Seventh Circuit does not point to any) that states or implies that policyholders or enrollees in the CancerCare Plan could separately purchase the rider, or had a "choice" between benefits provided by that rider or "all other benefits provided under the policy." (App. 10-11) Nothing in the language of that rider even suggests that the cancer treatment referenced therein "was considered a benefit distinct from all the other defined benefits included in the plan and the other riders." (App. 11)

A contract containing language whose meaning is disputed "'is not ambiguous if a court can discover its meaning simply through knowledge of those facts which give it meaning as gleaned from the general language of the contract.' . . . [citing *Flora Bank & Trust v. Czyzewski*, 222 Ill.App.3d 382, 164 Ill.Dec. 804, 809, 583 N.E.2d 720, 725 (1991)]" *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d at 1036. "A court's primary objective in construing the language of the [insurance] policy is to ascertain and give effect to the intentions of the parties as expressed in their agreement." *American States Insurance Co. v. Koloms*, 177 Ill.2d 473, 479, 687 N.E.2d 72, 75, 227 Ill.Dec. 149 (Ill. 1997).

Those two Illinois cases presume of course that in fairness the court will issue a ruling based on facts apparent from the record, and which cast particular light on that disputed meaning of the language. Thus, for example, the Seventh Circuit in *Bourke* (which concerned interpretation of an employment compensation contract) repeatedly cited to the specific location in the contract of provisions pertinent to the interpretation controversy, and thoroughly and methodically analyzed the language in those provisions.

Respondents' Point That CancerCare Plan Does Not Cover All Cancer Treatment is Moot, and Does Not Address Seventh Circuit's Erroneous Holding That CancerCare Does Not Cover Any Cancer Treatment

The Respondents' point that "The CancerCare Plan does not confer a general benefit for cancer 'treatment.' (App. 10)" (Brief pg. 8) is moot, because that is something the Petitioner has never denied or disputed. According to the Seventh Circuit (App. 10), the CancerCare Plan provides certain specified benefits, but the CancerCare Plan "policy itself does not generally cover cancer treatment **OR ANY TREATMENT AT ALL**" (emphasis added). That last part is quite untrue, as a check of the policy shows. Respondents follow the Seventh Circuit and continue to deny what is true – that the CancerCare Plan's purpose is to provide benefits for certain cancer treatments. Petitioner is therefore justified in specifically identifying where the CancerCare Plan group insurance policy (in the record as Appendix Exhibit D attached to the Appellant's Opening Brief in petitioner's appeal to the Seventh Circuit) repeatedly references the provision of benefits for treatment of cancer (emphases added in uppercase bold):

> Pg. 5, "CONFINED OR CONFINEMENT means that the Covered Person is a registered bed patient in a Hospital or Skilled Nursing Facility and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and **TREATMENT** of a Physician."
>
> Pg. 5, "HOSPITAL means an institution which meets all of the following requirements: . . . (2) it must give 24 hour medical care, diagnosis and **TREATMENT** to the sick or injured on an in-patient basis for which a charge is made; . . . "
>
> Pg. 6, "PHYSICIAN means a person licensed by the state in which he is resident to practice

the healing arts. He must be practicing within the scope of his license for the service or **TREATMENT** given."

Pg. 8, "CANCER INSURANCE BENEFIT . . . If the Covered Person receives **TREATMENT** for cancer, but positive diagnosis is not made during his lifetime, we will make payment if positive diagnosis is made after death."

Pg. 8, "HOSPITAL CONFINEMENT DAILY BENEFIT. We will pay the following benefit for Cancer **TREATMENT** provided the Covered Person is Hospital Confined. . . . Upon receipt of due proof that a Covered Person is Hospital Confined for the **TREATMENT** of Cancer, we will pay the benefit shown on the Schedule for each day of Confinement."

Pg. 8, "EXCLUSIONS. Benefits will not be paid under this Policy and any attached Rider for any expenses which result from: . . . (3) **TREATMENT** or services performed outside of the United States."

Pg. 8, "PRE-EXISTING CONDITION LIMITATION. No benefits will be payable for the Covered Person's Pre-Existing Conditions. They are defined as a Cancer that was positively diagnosed within five years prior to the Covered Person's Effective Date of Coverage under this Policy, or a Cancer for which **TREATMENT** has been received before the Covered Person has been insured for 30 days from his Effective Date of Coverage. We will, however pay benefits for Cancer diagnosed and treated within the first 30 days the Covered Person has been insured. Expenses for such **TREATMENT** are payable only if incurred after coverage has been in force for 12 consecutive months from the Effective Date."

Pg. 10, "CHOICE OF PHYSICIAN. The Covered Person is free to be **TREATED** by any Physician he chooses."

> "SKIN CANCER BENEFIT RIDER. . . . Upon receipt of due proof that a Covered Person incurred expenses for **TREATMENT** of Skin Cancer, we will pay the expenses of its removal."
>
> "SURGICAL AND ANESTHESIA BENEFIT RIDER. . . . Upon receipt of due proof that a surgical procedure for the **TREATMENT** of Cancer is performed on a Covered Person, we will pay the expense incurred for the procedure, including post-operative attendance. . . . For the purposes of this Rider, Operative Session means the continuous period of time during which surgical procedures are performed for the **TREATMENT** of Cancer, regardless of the number of procedures or the number of surgical incisions."
>
> "HOSPICE CARE BENEFIT RIDER. . . . Upon receipt of due proof that a Covered Person, following a Covered Hospital Confinement which lasted at least 3 consecutive day, incurs expenses for **TREATMENT** in a Hospice, we will pay the amount shown on the Schedule."
>
> "AMENDMENT. . . . The following definitions are added to the Definitions section: . . . **TREATMENT** means medical and surgical care by a licensed provider to detect or cure Cancer. This includes examination, diagnostic procedures, surgery (including pre- and post-operative care), prescribed medication, **AND THE APPLICATION OF REMEDIES AND THERAPY.**"

"Reference to the purpose of a contract can be a useful aid in construction. '[I]f the principal purpose of the parties is ascertainable it is given great weight.' Restatement (Second) of Contracts § 202(1)." *Bourke v. Dun & Bradstreet Corp.*, 159 F.3d at 1039.

Illinois law requires that provisions of an insurance agreement be interpreted in the factual context of the case. *Indiana Insurance Co. v. Pana Community Unit School District No. 8*, 314 F.2d 895, 900 (C.A.7 [Ill.] 2002).

(Pet. pg. 7) Petitioner has also pointed to pitch letters and brochures mailed by the Respondent to prospective enrollees, to promote the CancerCare Plan, which are persuasive evidence that the purpose of the CancerCare Plan was clearly represented to be and was understood to be to provide benefits for certain cancer treatments. (Pet. pp. 8-9) And at a still more basic level, the name of the plan is CancerCare, and "care" means "treatment." So clearly, to the reasonable person, all CancerCare Plan benefits are properly understood as being for various services constituting treatment of cancer.

"The determination of whether the terms of an insurance policy are ambiguous is made by reference to a reasonable person standard; 'the test is . . . what a reasonable person in the position of the insured would understand [the terms] to mean.' Id. [i.e., *Allstate Insurance Co. v. Smiley*, 276 Ill.App.3d 971, 659 N.E.2d 1345, 1350, 213 Ill.Dec. 698 (2 Dist. 1995)]" (App. 8)

Respondents' Points Concerning Omission in the "Blood and Plasma Benefit Rider" of the Word "Treatment" and Any Reference to Blood Processing and Transfusion Costs are Overruled by the Circumstances Surrounding the CancerCare Plan

Respondents make two points concerning the "Blood and Plasma Benefit Rider": it does not refer to blood processing and transfusion costs, and the word "treatment" does not appear there or in the policy's "Schedule of Benefits." This, according to the Respondents, supports their argument against interpreting "expenses for the cost of blood and blood plasma" as encompassing treatment using those substances. And the Seventh Circuit similarly attached significance, despite all evidence to the contrary, to the fact that "None of the other benefits were denominated 'treatment' by the policy. This supports the conclusion that the phrase 'cost of blood or blood plasma' means the cost of blood or plasma only and not the additional